SECTION 18
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services, and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent
Certificate of Medical Necessity (use the link at the CMS# 1500 claim line level)

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 573/751-2896.
- Go to the Medicaid Web site, www.dss.mo.gov/dms/providers.htm, and select and click on "Medicaid Forms" on the left side of the Web page..
- Use the Infocrossing order form found at the end of this section.

MO-8812

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE.** I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent

of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ _____
Interpreter Date

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____ _____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ , _____ ,
Name of individual to be sterilized *Medicaid number*

on _____ (Date of sterilization), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested).

- ☐ Premature delivery
- ☐ Individual's expected date of delivery:
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

_____ _____
Medicaid provider number *Date*

PSFL - 200
(Revised 11/01/00)

MISSOURI DEPARTMENT OF HEALTH

RISK APPRAISAL FOR PREGNANT WOMEN

INSTRUCTIONS ON REVERSE SIDE

DCN OR TEMP. NO	BIRTHDATE (MM/DD/YY)	DATE OF RISK APPRAISAL	PROVIDER NAME (ATTACH MEDICAID PROVIDER LABEL)
CLIENT'S NAME (LAST, FIRST, MI, MAIDEN)			ADDRESS (STREET)
ADDRESS (STREET)			CITY STATE ZIP CODE
CITY STATE ZIP CODE			MEDICAID PROVIDER NUMBER / MONTH PRENATAL CARE BEGAN ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9
TELEPHONE NUMBER ( )	COUNTY OF RESIDENCE		MARITAL STATUS CODE ☐S ☐M ☐W ☐D ☐SEP

RACE/ETHNICITY	HISPANIC ORIGIN	LMP (MM/DD/YY)	GRAVIDA	PARA	ABORTA
☐1. WHITE ☐2. BLACK ☐3. AM.IND/ALASKAN ☐4. ASIAN/PACIFIC ISLANDER ☐5. OTHER _____	☐ YES ☐ NO				

PUT AN "X" IN ALL THE BOXES BELOW THAT APPLY. AN "X" IN ANY ONE OF THE FIRST 34 RISK FACTOR BOXES QUALIFIES CLIENT FOR CASE MANAGEMENT SERVICES.

☐ 1. Mother's age 17 years of less at time of conception.

☐ 2. Mother's education less than 8 years.

☐ 3. Gravida greater than or equal to 7.

☐ 4. Smoking equal to or greater than one pack of cigarettes per day, IF CLIENT HAS STOPPED SMOKING BY THE 12TH WEEK OF GESTATION, CONSIDER AS NON SMOKING.

☐ 5. Mother's age 40 years or greater at time of conception.

☐ 6. Prepregnancy weight less than 100 lbs.

☐ 7. Previous fetal death (20 weeks gestation or later).

☐ 8. Previous infant death.

☐ 9. History of incompetent cervix in current or past pregnancy.

☐10. History of diabetes mellitus including gestational diabetes in current or past pregnancy.

☐11. Multiple fetuses in current pregnancy.

☐12. Pre-existing hypertension (a history of hypertension — 140/90 mm Hg or greater — antedating pregnancy or discovery of hypertension — 140/90 or greater — before the 20th week of pregnancy).

☐13. Pregnancy-induced hypertension in current pregnancy (blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart).

☐14. Prior low birth weight baby (<2500 grams or 5 lbs. 8 oz.).

☐15. Prior preterm labor (<37 completed weeks gestation).

☐16. Preterm labor: current pregnancy.

☐17. Seropositive for HIV antibodies.

☐18. Interconceptional spacing <1 year.

☐19. Living alone or single parent living alone.

☐20. Considered relinquishment of infant.

☐21. Poor environmental conditions.

☐22. Late entry into care (after 4th month or 18 weeks gestation).

☐23. Homelessness.

☐24. Alcohol abuse by client.

☐25. Alcohol abuse by partner.

☐26. Drug dependence or misuse by client.

☐27. Drug dependence or misuse by partner.

☐28. Physical or emotional abuse/neglect of client.

☐29. Physical abuse of children in the home.

☐30. Neglect of children in the home.

☐31. Partner with history of violence.

☐32. Chronic or recent mental illness and/or psychiatric treatment.

☐33. Elevated blood lead level 15ug/dl or greater.

☐34. Other, identify: _____

_____

☐99. None of the above.

FOLLOWING DOES NOT QUALIFY FOR CASE MANAGEMENT SERVICES. DATA COLLECTION IS NECESSARY FOR PROGRAM PLANNING. (CHECK ONE)

☐ 1. Intended pregnancy.
☐ 2. Unintended pregnancy using birth control
☐ 3. Unintended pregnancy not using birth control.
☐ 4. Unintended pregnancy - birth control unknown.

SPECIFY GESTATIONAL AGE AT TIME OF RISK APPRAISAL: WEEKS	APPROXIMATE DUE DATE MM DD YY	PHYSICIAN'S PERFORMING PROVIDER NUMBER
PROVIDER SIGNATURE ▶		DATE
PREFERRED CASE MANAGEMENT PROVIDER AGENCY		

MO 580-1171 (9-97) **DISTRIBUTION:** **WHITE/CANARY** - BSHCN/CASE MANAGEMENT AT TIME OF ENTRY **GREEN** - CLIENT **PINK** - CLIENT'S RECORD CM-4

MISSOURI MEDICAID
CERTIFICATE OF MEDICAL NECESSITY

	Patient Name			Medicaid ID Number	
	TOS	Procedure Codes (Maximum 6)	Description of Item/Service	Reason for Service	Months Equip. Needed (DME only):
1.					
2.					
3.					
4.					
5.					
6.					

Attending/Prescribing Physician Name		Attending/Prescribing Physician Medicaid Number
Date Prescribed	Diagnosis	Prognosis
Provider Name and Address		Provider Medicaid Number
Provider Signature		

MO-8813 PLEASE SUBMIT THIS FORM FOR EACH PROCEDURE REQUIRING DOCUMENTATION OF MEDICAL NECESSITY DS1960 (09/01/02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
EXCEPTIONS UNIT

MEDICAID EXCEPTION REQUEST

RETURN TO: ATTN EXCEPTIONS UNIT
DIVISION OF MEDICAL SERVICES
PO BOX 6500
JEFFERSON CITY MO 65102-6500
FAX NO: 573-522-3061

ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL BE RETURNED

FOR LIFE THREATENING EMERGENCIES
CALL 1-800-392-8030

PLEASE TYPE OR PRINT

RECIPIENT NAME	DATE OF BIRTH

RECIPIENT MEDICAID NUMBER (DCN)	SOCIAL SECURITY NUMBER

RECIPIENT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)

LIST ALL APPROPRIATE ALTERNATIVE COVERED SERVICES ATTEMPTED AND FOUND INEFFECTIVE FOR THIS DIAGNOSIS.

REQUESTED ITEM(S) OR SERVICE(S) (INCLUDING DAILY QUANTITY)

DURATION OF NEED

MISSOURI MEDICAID PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER)

NAME	TELEPHONE NUMBER
ADDRESS	PROVIDER NUMBER (IF KNOWN)
IS A HOME HEALTH AGENCY MAKING SKILLED NURSE VISITS? ☐ YES ☐ NO	AGENCY NAME
PRINT OR TYPE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE	TELEPHONE NUMBER
PRINT OR TYPE DOCTOR'S ADDRESS OR APN'S ADDRESS	FAX NUMBER
DOCTOR'S ORIGINAL SIGNATURE, OR APN'S ORIGINAL SIGNATURE AND TITLE (NO STAMPS OR PHOTOCOPIES) ▶	DATE

MO 886-3351 (3-02)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO **NOT** SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL **NOT** BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	

PROVIDER NAME

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___

INSURANCE COMPANY NAME

POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER

POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	

NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Return to: Infocrossing Healthcare Services, Inc.
PO Box 5700
Jefferson City, MO 65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION

16. REF. NO.	17. PROCEDURE CODE	18. MODIFIERS	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	FOR STATE USE ONLY APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF **PRESCRIBING PHYSICIAN/PRACTITIONER** | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (11-04) MO 880

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipient's Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipient's address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipient's prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening – Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Procedure Code – Enter the procedure code(s) for the services being requested.
18. Modifier – Enter the appropriate modifier(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter the specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid identification number.
28. Signature/Date – The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner – The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

DS1926

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID ACCIDENT REPORT

Submit this form to notify the Medicaid agency of information you have regarding a Medicaid recipient's accident or injury. Please send the completed form to:

Department of Social Services
Divison of Medical Services
Attention: TPL Casualty/Tort Recovery
P.O. Box 6500
Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

PROVIDER IDENTIFICATION NUMBER	DATE (MM/DD/YY)
PROVIDER NAME	DATES OF SERVICE
RECIPIENT NAME	MEDICAID NUMBER
DATE OF ACCIDENT/INJURY	APPROXIMATE TIME

TYPE OF ACCIDENT/INJURY

☐ AUTO ☐ WORK-RELATED ☐ OTHER (EXPLAIN)

ATTORNEY REPRESENTING RECIPIENT

RESPONSIBLE PARTY'S NAME	POLICY/CLAIM NUMBER

INSURANCE COMPANY NAME AND ADDRESS

HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.)

☐ YES ☐ NO

REMARKS

Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) if applicable.

THANK YOU FOR YOUR ASSISTANCE.

MO 886-3016 (3-93) TPL-2P

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A (All providers must complete this section)

1.TYPE OF DIRECT DEPOSIT ACTION➨ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➨

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION B (Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)

(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_____	_____

3. TYPE OF ACCOUNT (***must check one***) ➨ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

MO 886-3089 (3-2000) Page 1

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1. **Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION CHECK NO.4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION CHECK 4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

MO 886-3089 (3-2000) Page 2

MISSOURI MEDICAID
SECOND SURGICAL OPINION FORM

PLEASE PRINT OR TYPE

SECTION I: TO BE COMPLETED BY PRIMARY (FIRST OPINION) PHYSICIAN — MO-8807

RECIPIENT'S NAME (FIRST) (M.I.) (LAST)				RECIPIENT'S MEDICAID I.D. NUMBER	
SURGICAL PROCEDURE DISCUSSED & RECOMMENDED			CPT-4 PROCEDURE CODES		ICD-9-CM DX. CODE
PERTINENT HISTORY SYMPTOMS AND PHYSICAL FINDINGS					
PHYSICIAN'S NAME (FIRST) (MI) (LAST)				Physician's Mo. Medicaid Provider No.	
PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE	
APPOINTMENT DATE	PERSONAL SIGNATURE OF PRIMARY PHYSICIAN (NAME)			(DATE)	

REFER THIS FORM TO THE SECOND OPINION PHYSICIAN WITH RESULTS OF PATIENT'S HISTORY AND PHYSICAL REPORT, LABORATORY DATA, X-RAYS, ETC. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION II: TO BE COMPLETED BY SECOND SURGICAL OPINION PHYSICIAN

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED. IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES	ICD-9-CM DX. CODE
SECOND OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SECOND OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF SECOND OPINION PHYSICIAN (NAME)			(DATE)

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION III: TO BE COMPLETED BY THIRD SURGICAL OPINION PHYSICIAN

(A third surgical opinion is covered by Mo. Medicaid only if the second surgical opinion physician did not recommend surgery)

NEED FOR SURGERY ☐ CONFIRMED ☐ NOT CONFIRMED	STATE REMARKS:			
SURGICAL PROCEDURE RECOMMENDED, IF SURGERY CONFIRMED			CPT-4 PROCEDURE CODES	ICD-9-CM DX. CODE
THIRD OPINION PHYSICIAN'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
THIRD OPINION PHYSICIAN'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
APPOINTMENT DATE	PERSONAL SIGNATURE OF THIRD OPINION PHYSICIAN (NAME)			(DATE)

REFER THIS FORM BACK TO THE PRIMARY (FIRST OPINION) PHYSICIAN REFERENCED IN SECTION I. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND POSSIBLE CLAIM FILING NEEDS.

SECTION IV: TO BE COMPLETED BY SURGEON, IF SURGERY IS PERFORMED AT REQUEST OF RECIPIENT

SURGICAL PROCEDURE PERFORMED				CPT-4 PROCEDURE CODES
ICD-9-CM DX. CODE	SPECIFY NAME AND ADDRESS OF SURGERY SITE			
DATE OF SURGERY				
SURGEON'S NAME (FIRST) (M.I.) (LAST)				Physician's Mo. Medicaid Provider No.
SURGEON'S OFFICE ADDRESS (Street) (City) (State) (Zip Code)				SPECIALITY, IF APPLICABLE
PERSONAL SIGNATURE OF SURGEON (NAME)				(DATE)

THE SURGEON MUST ATTACH THIS COMPLETED SECOND SURGICAL OPINION FORM TO HIS MEDICAID CLAIM FOR THE SURGICAL PROCEDURE. IT IS THE SURGEON'S RESPONSIBILITY TO FURNISH A COPY OF THIS COMPLETED FORM TO THE HOSPITAL/ AMBULATORY SURGICAL CARE CENTER, IN ORDER THAT THE FACILITY MAY BILL MEDICAID FOR RELATED CHARGES. YOU SHOULD RETAIN A COPY OF THIS FORM FOR YOUR RECORDS.

DS1907 (02/01)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

This form must be completed when a hysterectomy is to be performed which is not precluded from Medicaid reimbursement under Federal regulatory provisions at 42 CFR 441.255(a) and which is not exempted from the requirement for this documentation under provisions at 42 CFR 441.255(d) or (e).

The requirement for Acknowledgement of Receipt of Hysterectomy Information applies to an individual of any age. The form must be signed by the recipient or her representative, if any, prior to the surgery. Hysterectomies for family planning purposes are not payable through Medicaid or any other federally funded program, nor from the general relief or blind pension programs.

1. NAME OF RECIPIENT	2. MEDICAID ID NUMBER	3. NAME OF REPRESENTATIVE

1. SOURCE OF HYSTERECTOMY INFORMATION

PART I
TO BE COMPLETED BY THE PERSON WHO SECURES THE AUTHORIZATION TO PERFORM THE HYSTERECTOMY

5. I certify that I have informed the above named recipient and her representative, if any, **orally and in writing,** that the hysterectomy will render her permanently incapable of reproducing. I further certify that the purpose for performing the hysterectomy is:

6. SIGNATURE AND TITLE OF PERSON SECURING AUTHORIZATION	7. DATE (MONTH/DAY/YEAR)

8. PHYSICIAN / CLINIC NAME	9. PROVIDER MEDICAID NUMBER
▶	

PART II COMPLETE A OR B

If B is completed, the reason the recipient is incapable of signing must be stated on the line provided in Item B. (B is not to be completed if the recipient is capable of signing in Item A.)

A. TO BE COMPLETED BY THE RECIPIENT RECEIVING THE HYSTERECTOMY PRIOR TO THE OPERATION

I have received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render me permanently incapable of reproducing. I understand that I will not be able to become pregnant or bear children.

10. SIGNATURE OF RECIPIENT	11. DATE (MONTH/DAY/YEAR)
▶	

B. TO BE COMPLETED BY A REPRESENTATIVE OF THE RECIPIENT RECEIVING THE HYSTERECTOMY

I, the representative named above, certify that the designated recipient accepts and understands that I am her representative and that she has received, **orally and in writing,** information from the above named source, stating that the hysterectomy will render her permanently incapable of reproducing. She understands that she will not be able to become pregnant or bear children.

12. REASON RECIPIENT INCAPABLE OF SIGNING

13. SIGNATURE OF REPRESENTATIVE	14. RELATIONSHIP TO RECIPIENT	15. DATE (MONTH/DAY/YEAR)
▶		

MO 886-3280 (11/01/00)

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Quantity Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

Nondiscrimination Policy Statement

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250